Department of HUMAN SERVICES

Health Home Learning Collaborative

Population Health

Risk Stratification

05/18/2020

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them and we will address them at the end.

This Training is a Collaborative Effort Between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

1. Introductions
2. Population Health and Risk Stratification.....Sara Hackbart, AGP
3. Discussion……...All

(Open discussion on current issues or barriers, potentially leading to future monthly topics)

Coming up (Subject to Change):

June 15 SPA Updates

July 20 Diabetes Self-Management Program

Aug 17 Person Centered Planning

Health Home Service

- Comprehensive Care Management
  - Predictive modeling reports generated through Medicaid data mining, identifying whole person risk information to be shared with IHH providers.
  - Administration of online provider tools, including Health and Wellness Questionnaire to assess initial risk level, and Care Coordination Plan
  - HIT- examples of technology support functions which may be employ by MCOs- predictive modeling and reporting tool to identify the population at risk including risks for hospital admission, gaps in care, and other claims-based data
- Provider Standards
  - Establishing a continuous quality improvement program… evaluation of increased coordination of care… and outcomes… at the population level

Learning Objectives

- Review concepts of population health
- Understand population health definitions
- Review basics of population health management including the use of risk stratification
- Look at results of IHH risk stratification survey from March 2020
- Examine risk stratification models

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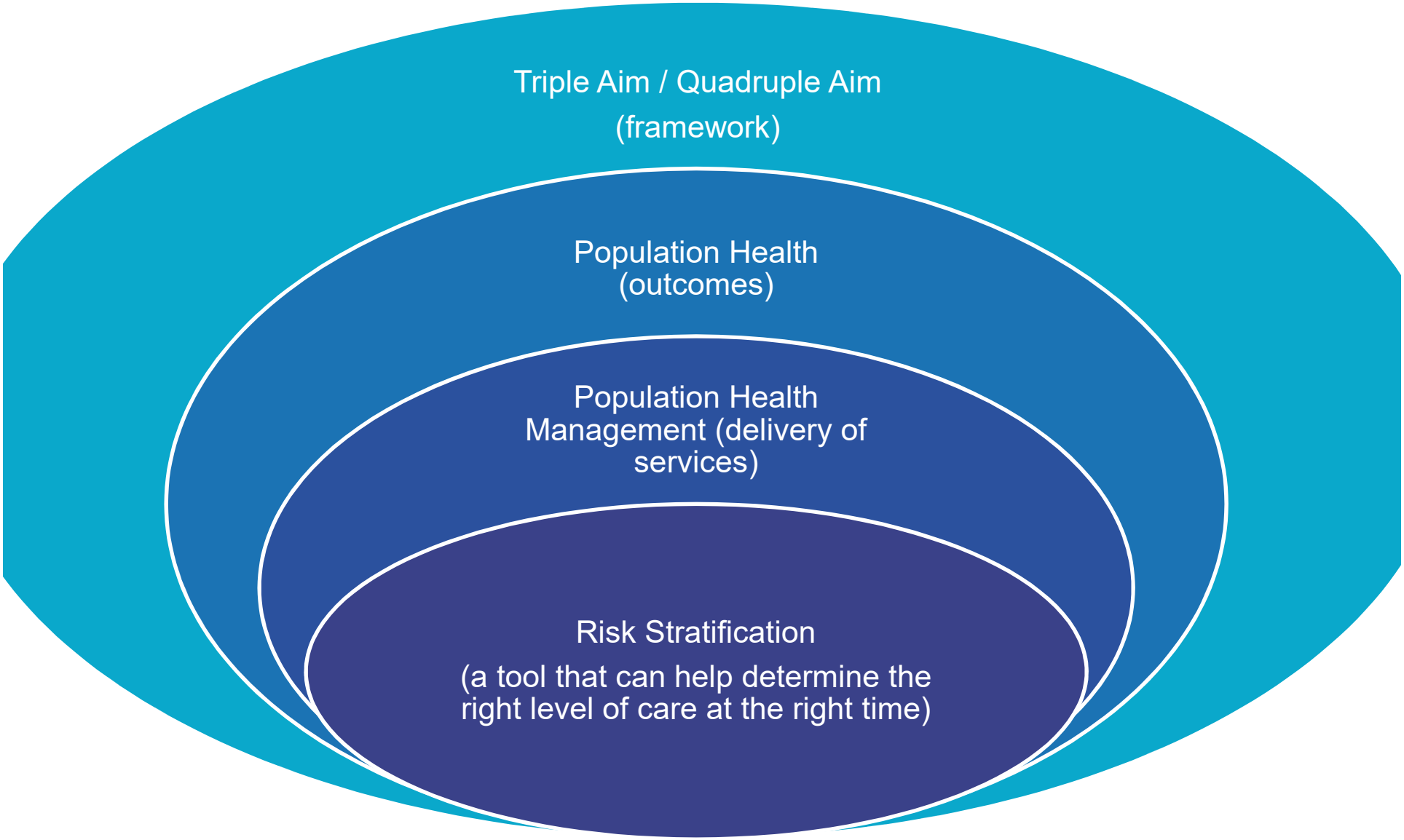
Population Health Overview

Concepts

- The **Triple Aim** is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance by:
  - Improving the patient experience of care
  - Improving the ***health of populations***, and
  - Reducing the per capita cost of health care
- The **Quadruple Aim** framework adds an additional component:
  - Improving the work life of health care providers
- **Population Health** is the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Concepts, cont'd

- **Population Health Management (PHM)** is a set of interventions designed to maintain and improve people's health across the full continuum of care- from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions
- **Risk Stratification** segments patients into distinct groups of similar complexity and care needs which enables providers to identify the right level of care and services for distinct subgroups of patients (e.g. DLA20, PRAPARE).
  - A patient's health status may be reflected by a score or placement in a specific category, based on the most current information available


Triple Aim / Quadruple Aim
(framework)
Population Health
(outcomes)
Population Health
Management (delivery of
services)
Risk Stratification
(a tool that can help determine the
right level of care at the right time)

Additional Population Health Concepts

Population Health Definitions

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Population Health Management

Know your population

Basics

- Population health management begins by:
  - Developing a strategic road map (i.e. policy and procedures)
  - Gathering key demographic and clinical data about patients which may also include calculating a risk score or assigning a risk category
  - Sorting patients into categories using their risk score (risk stratification) to determine the right care at the right time which also includes preventative care / gaps in care

Basics, cont'd

- Analyzing the population further to address specific health issues (e.g. diabetes, heart disease, smoking, obesity)
- Employing evidence based practices including referrals to evidence based programs
- Collecting feedback on workflows and patient satisfaction
- Measure outcomes

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Risk Stratification

The Need for Risk Stratification

- Predict risks- proactively identify patients at risk of unplanned hospital admissions, etc
- Individualized care plans- identifying patient-specific risk factors to tailor a care plan to their needs
- Understanding trends- providers can better understand their patient population

Survey- IHH

- Survey of IHHs (March 2020)
  - IHHs reporting: 21 out of 33 (64%)
    - Which risk stratification tool do you use?

Daily Living Activities (DLA20	4
Level of Care Utilization system (LOCUS)	1
Adjusted Clinical Groups (ACG) (John Hopkins University)	
Protocol for Responding to and assessing Patient Assets, Risks, and Experiences (PRAPARE)	
Patient Tiering and Assessment Tool (PTAT)	
Your own / one that was developed with Magellan	15
Other	1

Survey- IHH

– How often do you complete the risk stratification tool for each member?

At intake and then every 90 days	2
At intake and then every 6 months	3
At intake and annually or sooner if change in status	16
Other	

Survey- IHH

– How do you use your risk stratification tool? (e.g. to determine frequency of contact, to determine targeted interventions, etc)?

Frequency of contact	3
Degree of intervention / service needs	8
Frequency of contact and degree of intervention / service needs	5
Even out case loads and degree of intervention / service needs	1
No answer	4

Survey- CCHH

- Survey of IHHs (March 2020)
  - CCHHs reporting: 6 out of 13 (46%)
    - Which risk stratification tool do you use?

Daily Living Activities (DLA20	
Level of Care Utilization system (LOCUS)	
Adjusted Clinical Groups (ACG) (John Hopkins University)	
Protocol for Responding to and assessing Patient Assets, Risks, and Experiences (PRAPARE)	
Patient Tiering and Assessment Tool (PTAT)	6
Your own / one that was developed with Magellan	
Other	

Survey- CCHH

– How often do you complete the risk stratification tool for each member?

At intake and then every 90 days	
At intake and then every 6 months	
At intake and annually or sooner if change in status	5
Other	1

Survey- CCHH

– How do you use your risk stratification tool? (e.g. to determine frequency of contact, to determine targeted interventions, etc)?

Frequency of contact	
Degree of intervention / service needs	5
Frequency of contact and degree of intervention / service needs	1
Even out case loads and degree of intervention / service needs	

Risk Stratification Models

- Many electronic health records (EHRs) have built in risk stratification capabilities
- The risk stratification tool you use depends on what you are trying to accomplish (SPA / larger agency and community goals) and how feedback loops and data are used for adjustments

Risk Stratification Models, cont'd

- Hierarchical Condition Categories (HCCs)
  - Designed as part of the Medicare Advantage Program by CMS.
  - Incorporates 70 conditions
- Adjusted Clinical Groups (ACG)
  - Developed by John Hopkins University
  - Uses inpatient and outpatient diagnoses and predicts hospital utilization

Risk Stratification Models, cont'd

- Chronic Comorbidity Count (CCC)
  - Total count of selected comorbid conditions over six categories
  - Uses public data from the Agency for Healthcare Research and Quality
- Daily Living Activities-20 (DLA-20)
  - 30 day snap shot of 20 domains and a summary of strengths and needs
  - Copyrighted tool, initial 3.5 hour training

Risk Stratification Models, cont'd

- A Level of Care Utilization System (LOCUS)
  - Determines the resource intensity needs of individuals who receive adult mental health services.
- Patient Tiering and Assessment Tool (PTAT)
  - Uses expanded diagnostic clusters (EDC)
  - Identifies the complexity of a patient and tier

Risk Stratification Models, cont'd

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
  - National effort
  - Collects data needed to better understand patients' social determinants of health
  - Data from PRAPARE is updated in EHR and combined with data from other clinic systems
- Your own / Magellan

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Health Home Spotlight

Abbe Center IHH

People's Clinic CCHH

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Health Home Spotlight

People's Clinic CCHH

Our Services & Providers

Comprehensive Health Care

- Medical Care
- Dental Care
- Urgent Care
- Counseling - Family Concerns, Substance Abuse Problems, Nutritional Concerns, and Homelessness
- Laboratory
- Pharmacy
- X-Ray

Additional Support

- Benefit Counseling to Determine Financial Eligibility for Health Care Services
- Care for Children with Special Health Care Needs
- Chronic Care Management
- Health Care for the Homeless Program
- Health Education and Community Health Promotion Programs
- Interpreters On-Site: Bosnian, Spanish, Burmese and French
- Medication Assistance Program
- Substance Use Disorder Counseling
- Pediatrician Hospital Visits
- Reach Out and Read Pediatric Literacy Program

Medical & Dental Providers

Physicians

- 4 Family Practice Physicians
- 2 Internal Medicine Physicians
- 6 Pediatricians

Mid-Levels

- 9 Nurse Practitioners
- 1 Physician Assistant
- 2 Psych Nurse Practitioners
- 1 Midwife

Dental

- 4 General Dentists
- 34 Dental Hygienists

PRAPARE

- Social Determinants of Health
  - Protocol for
  - Responding to and
  - Assessing
  - Patient
  - Assets
  - Risks and
  - Experiences

PRAPARE WORKFLOW

- Implemented to daily huddle protocol
- Built in template in EMR
- Monitor trends, look for missed opportunities
- Staff adherence to protocol
- Share experiences on department meetings
- Staff encouragement
- Behavioral Health Counselors

Risk Assessments

- SBIRT annually for 18 years and older
  - DAST for drug assessment
  - AUDIT for alcohol assessment
  - Brief intervention by CADC or referral for treatment
- AHA/ACC-ASCVD Risk Estimator calculator
  - Annual visits
  - Disease Management template
- Framingham Risk Calculator
  - Annual visits
  - Disease Management template

Risk Assessments

- Sexual Risk Assessment
  - annual female visit
  - not a good assessment for males
  - Behavioral Health to assess

Risk Assessments

- Depression
  - PHQ2
    - Annually 12 years and older
    - If positive, PHQ9 done
  - PHQ 9
    - Behavioral Health referral
    - Behavioral Health assess with patient permission at time of visit
  - Fall Risk
    - Medicare annual wellness visits

Thank you!

FAQs from Survey

Q: (IHH) What is the risk strat actually supposed to be measuring and how is it to be used? I don't feel like we see a beneficial purpose for this

A: The risk stratification tool helps to predict risks, individualize care plans, and understand trends within the population.

FAQs from Survey, cont'd

Q: (IHH) Does our risk strat tool give and accurate risk level? Can this be shortened?

A: Depends on what you are trying to target. Through your QI process, you may choose to shorten your tool to be more effective.

Q: (IHH) What is actually required?

A: Assess initial risk level, understand risks at a population level, QI process (see SPA)

FAQs from Survey, cont'd

Q: (IHH) I understand the value of completion of the tool at the time of intake, but given the required need for a monthly deliverable, how is the information to be utilized for population health management?

A: The basis of risk strat and population health is the right care at the right time. Using a risk strat tool and understanding the components of population health can assist with monitoring for gaps in care, the minimum service required for a PMPM.

FAQs from Survey, cont'd

Q: (IHH) Just wondering if there are other risk strats that IHH's are using that we might be able to make better use of, or what they are using the risk strat for.

A: The next face to face will provide an opportunity for peer sharing on risk stratification tools

FAQ from Survey, cont'd

Q: (IHH) Could you please explain what contacts and interventions would look like based on risk stratification and how that applies to Population Health management?

A: The basis of risk strat and population health is the right care at the right time. Using a risk strat tool and understanding the components of population health can assist with monitoring for gaps in care, the minimum service required for a PMPM.

Questions?

Open Discussion

Thank you!